Senate Bill No. 1461

CHAPTER 176

An act to amend Sections 124900, 124910, 124920, and 124930 of, and to repeal Sections 124906 and 124927 of, the Health and Safety Code, relating to health care.

[Approved by Governor August 28, 2006. Filed with Secretary of State August 28, 2006.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1461, Florez. Health care: primary care: grants in aid.

Existing law requires the State Department of Health Services to select certain primary care clinics to be reimbursed for delivering medical services, including preventative health care, and smoking prevention and cessation health education to program beneficiaries, based upon specified criteria.

This bill would delete obsolete provisions governing the reimbursement of those services during prior fiscal years. Existing law requires each primary care clinic, applying for funds pursuant to the program, to demonstrate that it meets specified conditions, including, among other things, that it is located in an area federally designated as a medically underserved area, or medically underserved population.

This bill would revise those conditions to require that a primary care clinic be located in an area or a facility federally designated as a health professional shortage area, medically underserved area, or medically underserved population, and would make related changes.

The people of the State of California do enact as follows:

SECTION 1. Section 124900 of the Health and Safety Code is amended to read:

124900. (a) (1) The State Department of Health Services shall select primary care clinics that are licensed under paragraph (1) or (2) of subdivision (a) of Section 1204, or are exempt from licensure under subdivision (c) of Section 1206, to be reimbursed for delivering medical services, including preventive health care, and smoking prevention and cessation health education, to program beneficiaries.

(2) In order to be eligible to receive funds under this article a clinic shall meet all of the following conditions, at a minimum:

(A) Provide medical diagnosis and treatment.

(B) Provide medical support services of patients in all stages of illness.

(C) Provide communication of information about diagnosis, treatment, prevention, and prognosis.

(D) Provide maintenance of patients with chronic illness.

(E) Provide prevention of disability and disease through detection, education, persuasion, and preventive treatment.

(F) Meet one or both of the following conditions:

(i) Are located in an area or a facility federally designated as a health professional shortage area, medically underserved area, or medically underserved population.

(ii) Are clinics that are able to demonstrate that at least 50 percent of the patients served are persons with incomes at or below 200 percent of the federal poverty level.

(3) Notwithstanding the requirements of paragraph (2), all clinics that received funds under this article in the 1997–98 fiscal year shall continue to be eligible to receive funds under this article.

(b) As a part of the award process for funding pursuant to this article, the department shall take into account the availability of primary care services in the various geographic areas of the state. The department shall determine which areas within the state have populations which have clear and compelling difficulty in obtaining access to primary care. The department shall consider proposals from new and existing eligible providers to extend clinic services to these populations.

(c) Each primary care clinic applying for funds pursuant to this article shall demonstrate that the funds shall be used to expand medical services, including preventive health care, and smoking prevention and cessation health education, for program beneficiaries above the level of services provided in the 1988 calendar year or in the year prior to the first year a clinic receives funds under this article if the clinic did not receive funds in the 1989 calendar year.

(d) (1) The department, in consultation with clinics funded under this article, shall develop a formula for allocation of funds available. It is the intent of the Legislature that the funds allocated pursuant to this article promote stability for those clinics participating in programs under this article as part of the state's health care safety net and at the same time be distributed in a manner that best promotes access to health care to uninsured populations.

(2) The formula shall be based on both of the following:

(A) A hold harmless for clinics funded in the 1997–98 fiscal year to continue to reimburse them for some portion of their uncompensated care.

(B) Demonstrated unmet need by both new and existing clinics, as reflected in their levels of uncompensated care reported to the department. For purposes of this article, "uncompensated care" means clinic patient visits for persons with incomes at or below 200 percent of the federal poverty level for which there is no encounter-based third-party reimbursement which includes, but is not limited to, unpaid expanded access to primary care claims.

(3) The department shall allocate available funds, for a three-year period, as follows:

(A) Clinics that received funding in the prior fiscal year shall receive 90 percent of their prior fiscal year allocation, subject to available funds, provided that the funding award is substantiated by the clinics' reported levels of uncompensated care.

(B) The remaining funds beyond 90 percent shall be awarded to new and existing applicants based on the clinics' reported levels of uncompensated care as verified by the department according to subparagraph (B) of paragraph (4). The department shall seek input from stakeholders to discuss any adjustments to award levels that the department deems reasonable, such as including base amounts for new applicant clinics.

(C) New applicants shall be awarded funds pursuant to this subdivision if they meet the minimum requirements for funding under this article based on the clinics' reported levels of uncompensated care as verified by the department according to subparagraph (A) of paragraph (4). New applicants include applicants for any new site expansions by existing applicants.

(4) In assessing reported levels of uncompensated care, the department shall utilize the data available from the Office of Statewide Health Planning and Development's (OSHPD) completed analysis of the "Annual Report of Primary Care Clinics" for the prior fiscal year, or if more recent data is available, then the most recent data. If this data is unavailable for an existing applicant to assess reported levels of uncompensated care, the existing applicant shall receive an allocation pursuant to subparagraph (A) of paragraph (3).

(A) The department shall utilize the most recent data available from OSHPD's completed analysis of the "Annual Report of Primary Care Clinics" for the prior fiscal year, or if more recent data is available, then the most recent data.

(B) If the funds allocated to the program are less than the prior year, the department shall allocate available funds to existing program providers only.

(5) The department shall establish a base funding level, subject to available funds, of no less than thirty-five thousand dollars ($35,000) for frontier clinics and Native American reservation-based clinics. For purposes of this article, "frontier clinics" means clinics located in a medical services study area with a population of fewer than 11 persons per square mile.

(6) The department shall develop, in consultation with clinics funded pursuant to this article, a formula for reallocation of unused funds to other participating clinics to reimburse for uncompensated care. The department shall allocate the unused funds remaining on October 30, for the prior fiscal year to other participating clinics to reimburse for uncompensated care.

(e) In applying for funds, eligible clinics shall submit a single application per clinic corporation. Applicants with multiple sites shall apply for all eligible clinics, and shall report to the department the allocation of funds among their corporate sites in the prior year. A corporation may only claim reimbursement for services provided at a program-eligible clinic site identified in the corporate entity's application for funds, and approved for funding by the department. A corporation may increase or decrease the number of its program-eligible clinic sites on an annual basis, at the time of the annual application update for the subsequent fiscal years of any multiple-year application period.

(f) Grant allocations pursuant to this article shall be based on the formula developed by the department, notwithstanding a merger of one of more licensed primary care clinics participating in the program.

(g) A clinic that is eligible for the program in every other respect, but that provides dental services only, rather than the full range of primary care medical services, shall only be eligible to receive funds under this article on an exception basis. A dental-only provider's application shall include a memorandum of understanding (MOU) with a primary care clinic funded under this article. The MOU shall include medical protocols for making referrals by the primary care clinic to the dental clinic and from the dental clinic to the primary care clinic, and ensure that case management services are provided and that the patient is being provided comprehensive primary care as defined in subdivision (a).

(h) (1) For purposes of this article, an outpatient visit shall include diagnosis and medical treatment services, including the associated pharmacy, X-ray, and laboratory services, and prevention health and case management services that are needed as a result of the outpatient visit. For a new patient, an outpatient visit shall also include a health assessment encompassing an assessment of smoking behavior and the patient's need for appropriate health education specific to related tobacco use and exposure.

(2) "Case management" includes, for this purpose, the management of all physician services, both primary and specialty, and arrangements for hospitalization, postdischarge care, and followup care.

(i) (1) Payment shall be on a per-visit basis at a rate that is determined by the department to be appropriate for an outpatient visit as defined in this section, and shall be not less than seventy-one dollars and fifty cents ($71.50).

(2) In developing a statewide uniform rate for an outpatient visit as defined in this article, the department shall consider existing rates of payments for comparable outpatient visits. The department shall review the outpatient visit rate on an annual basis.

(j) Not later than June 1 of each year, the department shall adopt and provide each licensed primary care clinic with a schedule for programs under this article, including the date for notification of availability of funds, the deadline for the submission of a completed application, and an anticipated contract award date for successful applicants.

(k) In administering the program created pursuant to this article, the department shall utilize the Medi-Cal program statutes and regulations pertaining to program participation standards, medical and administrative recordkeeping, the ability of the department to monitor and audit clinic records pertaining to program services rendered to program beneficiaries and take recoupments or recovery actions consistent with monitoring and audit findings, and the provider's appeal rights. Each primary care clinic applying for program participation shall certify that it will abide by these statutes and regulations and other program requirements set forth in this article.

SEC. 2. Section 124906 of the Health and Safety Code is repealed.

SEC. 3. Section 124910 of the Health and Safety Code is amended to read:

124910. (a) (1) Each licensed primary care clinic, as specified in subdivision (a) of Section 124900, applying for funds under this article, shall demonstrate in its application that it meets all of the following conditions, at a minimum:

(A) Provides medical diagnosis and treatment.

(B) Provides medical support services of patients in all stages of illness.

(C) Provides communication of information about diagnosis, treatment, prevention, and prognosis.

(D) Provides maintenance of patients with chronic illness.

(E) Provides prevention of disability and disease through detection, education, persuasion, and preventive treatment.

(F) Meets one or both of the following conditions:

(i) Is located in an area or a facility federally designated as a health professional shortage area, medically underserved area, or medically underserved population.

(ii) Is a clinic in which at least 50 percent of the patients served are persons with incomes at or below 200 percent of the federal poverty level.

(2) Any applicant who has applied for and received a federal or state designation for serving a health professional shortage area, medically underserved area, or population shall be deemed to meet the requirements of subdivision (a) of Section 124900.

(b) Each applicant shall also demonstrate to the satisfaction of the department that the proposed services supplement, and do not supplant, those primary care services to program beneficiaries that are funded by any county, state, or federal program.

(c) Each applicant shall demonstrate that it is an active Medi-Cal provider by having a Medi-Cal provider number and diligently billing the Medi-Cal program for services rendered to Medi-Cal eligible patients during the past three months prior to the application due date. This subdivision shall not apply to clinics that are not currently Medi-Cal providers, and were funded participants pursuant to this article during the 1993–94 fiscal year.

(d) Each application shall be evaluated by the state department prior to funding to determine all of the following:

(1) The applicant shall provide its most recently audited financial statement to verify budget information.

(2) The applicant's ability to deliver basic primary care to program beneficiaries.

(3) A description of the applicant's operational quality assurance program.

(4) The applicant's use of protocols for the most common diseases in the population served under this article.

SEC. 4. Section 124920 of the Health and Safety Code is amended to read:

124920. (a) The department shall utilize existing contractual claims processing services in order to promote efficiency and to maximize use of funds.

(b) The department shall certify which primary care clinics are selected to participate in the program for each specific fiscal year, and how much in program funds each selected primary care clinic will be allocated each fiscal year.

(c) The department shall pay claims from selected primary care clinics up to each clinic's annual allocation. Once a clinic has exhausted its annual allocation, the state shall stop paying its program claims.

(d) The department may adjust any selected primary care clinic's allocation to take into account:

(1) An increase in program funds appropriated for the fiscal year.

(2) A decrease in program funds appropriated for the fiscal year.

(3) A clinic's projected inability to fully spend its allocation within the fiscal year.

(4) Surplus funds reallocated from other selected primary care clinics.

(e) The department shall notify all affected primary care clinics in writing prior to adjusting selected primary care clinics' allocations.

(f) Cessation of program payments under subdivision (e) or adjustment of selected primary care clinic's allocations under subdivision (d) shall not be subject to the Medi-Cal appeals process referenced in subdivision (g) of Section 124900.

(g) A clinic's allocation under this article shall not be reduced solely because the clinic has engaged in supplemental fundraising drives and activities, the proceeds of which have been used to defray the costs of services to the uninsured.

SEC. 5. Section 124927 of the Health and Safety Code is repealed.

SEC. 6. Section 124930 of the Health and Safety Code is amended to read:

124930. (a) For any condition detected as part of a child health and disability prevention screen for any child eligible for services under Section 104395, if the child was screened by the clinic or upon referral by a child health and disability prevention program provider, unless the child is eligible to receive care with no share of cost under the Medi-Cal program, is covered under another publicly funded program, or the

services are payable under private coverage, a clinic shall, as a condition of receiving funds under this article, do all of the following:

(1) Insofar as the clinic directly provides these services for other patients, provide medically necessary followup treatment, including prescription drugs.

(2) Insofar as the clinic does not provide treatment for the condition, arrange for the treatment to be provided.

(b) (1) If any child requires treatment the clinic does not provide, the clinic shall arrange for the treatment to be provided, and the name of that provider shall be noted in the patient's medical record.

(2) The clinic shall contact the provider or the patient or his or her guardian, or both, within 30 days after the arrangement for the provision of treatment is made, and shall determine if the provider has provided appropriate care, and shall note the results in the patient's medical record.

(3) If the clinic is not able to determine, within 30 days after the arrangement for the provision of treatment is made, whether the needed treatment was provided, the clinic shall provide written notice to the county child health and disability prevention program director, and shall also provide a copy to the state director of the program.

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